MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02382

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Winchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Winchester
(If outside city or town limits, write RURAL and give nearest town)
Street No. (E. J. Dodson's Farm)
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Gertrude Avery

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Colored	married

6.(b) Name of husband or wife unknown
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) unknown 1918

8. AGE: Years	Months	Days	If less than one day
30			...hrs. ...min.

9. Birthplace Marion N. C.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name Charles Carson
13. Birthplace N. C.
MOTHER 14. Maiden name Malinday Martin
15. Birthplace N. C.
16. Informant Family by Telephone
Address Marion N. C.
17. Shipped (Burial, cremation, or removal. Which?) Date thereof Mar. 4 1948 (month) (day) (year)
Cemetery or crematory Glades
Location Marion, N. C.
18. Funeral director J. B. Altman
Address Jonbadolus
19. March 3 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1948 at 9:30 P. M.
21. I CERTIFY that death occurred on the date above stated: Post mortem Examination March 1 1948

	DURATION
Immediate cause of death	
Second + third degree	
Due to burns over 3/4 of body	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accidental Date of Feb. 29 1948
Where did injury occur? Winchester (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Dodson home.
Means of injury clothes caught on fire Injured at work? no.

23. SIGNATURE John M. Claffy M.D Deputy Medical Examiner
M. D. or other
Address Annapolis, Md Date signed 3-3-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940 02383

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 509 Chesapeake Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: George L. Ball

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Harriett V. Ball

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 29th 1899

8. AGE:

Years	Months	Days	If less than one day
48	8	26	..... hrs. ..... min.

9. Birthplace: Catonsville Md.
(Town, county, and state)

10. Usual occupation: Laundryman (Chief)

11. Industry or business: U.S.N. Academy

FATHER
12. Name: George L. Ball
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rebecca Umbaugh
15. Birthplace: Maryland

16. Informant: Mrs. H. V. Ball

Address: Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/27/48 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Baltimore, Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. March 27 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 19 48, at 5a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 19 48 to March 25 19 48 and that I last saw h... alive on March 25 19 48

Immediate cause of death	DURATION
Coronary Thrombosis	Several hours
Due to	
Due to	
Other conditions Coronary Sclerosis	Autumn

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: George L. Ball M. D. or other

Address: Annapolis Md. Date signed 3-26-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

02384 22

Reg. Diat. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Odenton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Odenton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5-A M.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jennie Louise Barkley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 14, 1881

8. AGE: Years	Months	Days	If less than one day
67	1	13	..... hrs. ..... min.

9. Birthplace: Albany New York (town, county, and state)

10. Usual occupation: House work

11. Industry or business

FATHER — 12. Name: Thomas J. Bartley

FATHER — 13. Birthplace: Albany N.Y.

MOTHER — 14. Maiden name: Delia Kahnick

MOTHER — 15. Birthplace: Germany

16. Informant: Sadie Lindeman

Address: Odenton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 31 1948 (month) (day) (year)

Cemetery or crematory: Ivy Hill

Location: Laurel Md

18. Funeral director: Ridgely Selby

Address: 401 Wash Ave Laurel Md

19. Mar 30 19 48 (Date rec'd by registrar) Clara Karlup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 27 19 48 at 11 59 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19..... to ..... 19.....

~~and that I last saw him~~ ..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. Preston Ritchie, M.D. (M.D. or other authority)

Address: Annapolis, Md. Date signed: Mar. 28, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51b 02385

CERTIFICATE OF DEATH

Reg. Diat. No. 23

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Southern Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Southern Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 407 Maple Road.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Edward J. Brady

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 14 1874

8. AGE: Years: 73 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Md. Lithographing Co.

FATHER
12. Name: John J. Brady
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Sarah A. Trinty
15. Birthplace: Baltimore Md

16. Informant: Miss Margaret E. Brady
Address: 407 W. Maple Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Cathedral Cemetery

Location: Baltimore Md.

16. Funeral director: Flynn & Flemming

Address: 1426 Light St.

19 27 March 19 48 Caldwell Woodward Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1948 at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to March 26 1948

and that I last saw h[illegible] alive on March 26 1948

	DURATION
Immediate cause of death: Degeneration Cardio - Vascular Lesions	5 years
Due to: Arteriosclerosis	5 years
Due to:	
Other conditions: Carcinoma of Prostate	2 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Brady Smith M.D.
M. D. or other

Address: Riviera Beach Md. Date signed: 3/26/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Purvis

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48b 02386

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
AT RESIDENCE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.Co.
City or town: ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 17 REVELL ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LILLIAN G. BRADY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: THEODORE C. BRADY
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): SEPT. 4th 1896

8. AGE:

Years	Months	Days	If less than one day
51	6	27	hrs. min.

9. Birthplace: ANNAPOLIS, A.A.Co. Md.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: —
FATHER
12. Name: Wm E. CAMPBELL
13. Birthplace: A.A.Co. Md.
MOTHER
14. Maiden name: MARY E. PUCKETT
15. Birthplace: A.A.Co. Md.
16. Informant: Edith GROW
Address: ANNAPOLIS, Md.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 4/2/48 (month) (day) (year)
Cemetery or crematory: ST. MARY'S CEMETERY
Location: ANNAPOLIS, Md.
18. Funeral director: JOHN M. TAYLOR · SON
Address: ANNAPOLIS, Md.
19. April 1, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1948 at 9.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1947 to March 30 1948 and that I last saw h[illegible] alive on March 30 1948

Immediate cause of death: Cancer of Uterus — DURATION: about 1 yr
Due to: Carcinoma Abdomina — brief months
Due to: Hemorrhage — about 4 days
Due to: Anemia
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other
Address: Annapolis Md. Date signed: 3/31/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 B 02387

Reg. Dist. No. 29

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4656 Falls Rd

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Olivia Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE: Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER 12. Name: Caleb Brown

13. Birthplace: Md.

MOTHER 14. Maiden name: Mary Glover

15. Birthplace: Md.

16. Informant: Hospital records

Address: Crownsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-24-48 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore, Md.

18. Funeral director: Mrs. Francis A. Hunsley

Address: 578 W. Biddle St.

19. 3/24/48 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1948 at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1948 to March 21 1948 and that I last saw h. alive on March 20 1948

Immediate cause of death: Generalized arteriosclerosis — DURATION

Due to:

Due to:

Other conditions: Cerebral arteriosclerosis with psychosis

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

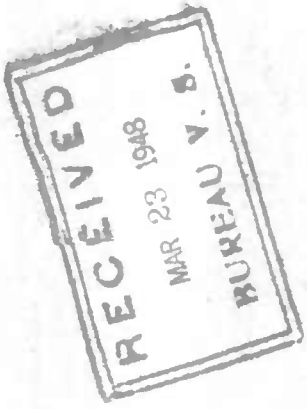
Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Mongeuste M.D. M. D. or other

Address: Date signed

F. A. Hartley



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

02388

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Junction

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Annapolis Junction

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Colin Campbell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Minnie Campbell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 6, 1864

8. AGE: Years 83 | Months 9 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Guard

11. Industry or business Md. House of Correction

FATHER 12. Name Henry Campbell

FATHER 13. Birthplace Scotland

MOTHER 14. Maiden name Margaret Taylor

MOTHER 15. Birthplace Scotland

16. Informant Mrs. Minnie Campbell

Address Annapolis Junction Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 13 1948 (month) (day) (year)

Cemetery or crematory Ardenwood Mem Gdns

Location Laurel, Md.

18. Funeral director The Wm. H. Deale Co

Address Laurel, Md.

19. Mar 16 1948 (Date rec'd by registrar) Clara Kasluh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1948 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 13 1948 to March 10 1948 and that I last saw h.. alive on March 9 1948

Immediate cause of death	DURATION
Massive Pulmonary Haemorrhage	5 min.
Due to Primary Carcinoma of left lung - inoperable	6 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Frank S. Ripley, M.D.

M. D. mother

Address Savage, Md. Date signed 3/13/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Unit 8
82 Ad

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

84a 02389 B

Reg. Diat. No. 22

1. PLACE OF DEATH:

County Anne Arundel

City or town Laurel (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred:
District Training School

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ..... County .....

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 522 1st St. S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME William Latham Carter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 25, 1935

8. AGE: Years	Months	Days	If less than one day
12	8		..... hrs. ..... min.

9. Birthplace Rock Hill S.C.
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

FATHER
12. Name Boyce Rosebough
13. Birthplace

MOTHER
14. Maiden name Gerania Bell
15. Birthplace Rock Hill S.C.

16. Informant History & District Training School
Address Laurel, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Mar. 25, 1948 (month) (day) (year)

Cemetery or crematory .....

Location Rock Hill, S.C.

18. Funeral director John J Rhines & Co.

Address 901-3rd St. S.W.

Mar 26 19 48 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 19 48, at 10:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 19 48 to March 25 19 48 and that I last saw h.i.m. alive on March 25 19 48

Immediate cause of death	DURATION
Pneumonia, hypostatic (4/26/48 also)	
oral + Pharyngeal Sepsis	
Due to	
.....	
Due to	
.....	
Other conditions ~~other conditions~~	
mental deficiency - idiot	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R O Hupp M. D. or other

Address Laurel, Md. Date signed 3/25/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of place and date of burial & addition of Jun. dir. shown on 83a

FILM No. G 114 MAR 22 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02390

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution? Admitted March 13-48

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8 Cypress Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Martina Cole

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Widow

6.(b) Name of husband or wife: George Thomas Cole
6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.): 1889

8. AGE: Years: 59 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Esset Co. Virginia (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: None

FATHER
12. Name: Wake Bratton
13. Birthplace: Esset Co. Virginia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Esset Co. Virginia

16. Informant: William Bratton
Address: 515 Okford St Baltimore L. Md.

17. Burial (Burial, cremation, or removal?) Date thereof: March 18 (month) (day) 1948 (year)
Cemetery or crematory: Brewer Hebrew Cemetery
Location: [illegible] Md.

18. Funeral director: Mrs Charles O. Hicks
Address: 45 Northwest St Annapolis Md.

19. March 17 48 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 1948 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13 1948 to March 14 1948 and that I last saw h[illegible] alive on March 14 1948

Immediate cause of death: Cerebral hemorrhage — DURATION: 36 hrs.
Due to: Uremia
Due to:
Other conditions: Obesity
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W K Lowrans MD M. D. or other
Address: Annapolis Md Date signed: 3/16/48

V8 A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02391

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 11 months, 1 day

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 year, 11 months, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 313 N. Jonathan
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: GARLAND COOK

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 4/28/1911

8. AGE: Years	Months	Days	If less than one day
36	10	2	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: unknown ✓

13. Birthplace: ✓

MOTHER — 14. Maiden name: Amanda? ✓

15. Birthplace: ✓

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof March 4th 48 (month) (day) (year)

Cemetery or Crematory: Falson Chapel

Location: Sharpsburg Md

18. Funeral director: William H Downey

Address: 291 Frederick St Hagerstown Md

19. 3/2 1948 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1st 1948 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29th 1946 to March 1st 1948 and that I last saw him alive on March 1st 1948

Immediate cause of death	DURATION
General Paresis	Known to us since 3/29/1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of .....

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----------

Means of injury: ..... Injured at work?

23. SIGNATURE: David Morgenstern M. D. M. D. or other

Address: Crownsville, Maryland Date signed: 3/1/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02392

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 321 Maple Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: GEORGE J. COOK

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elna Y Cook

Nee Yates 6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): October 28, 1889

8. AGE:

Years	Months	Days	If less than one day
58	4	26	....hrs. ....min.

9. Birthplace: Rock Point, Anne Arundel Co. Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Henry D. Cook

13. Birthplace: Anne Arundel Co. Md.

MOTHER 14. Maiden name: Sarah Chard

15. Birthplace: Anne Arundel Co. Md.

16. Informant: Mrs. George J. Cook

Address: 321 Maple Rd. Linthicum Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 27, 48 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Brooklyn Md. R.F.D.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 3/25/48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24 19 48 at 9.35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 19 47, to MARCH 19 48 and that I last saw h[illegible] alive on MARCH 23 19 48

Immediate cause of death	DURATION
INANITION	
Due to PARKINSONIAN SYNDROME	
Due to UNKNOWN	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of Injury: Injured at work?

23. SIGNATURE: Henry F. Langan M.D / M. D. or other

Address: Glen Burnie, Md. Date signed: 3/24/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

117a

03277

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glenburnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants give residence of mother)
State: Md. County: A-A.
City or town: Glenburnie Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Herbert McKenzie Crandall

3.(b) Social Security Number: 220,22,4014

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 29, 1886

8. AGE: Years: 61 | Months: 11 | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Glenburnie Md
(Town, county, and state)

10. Usual occupation: Retired Merchant

11. Industry or business: Grocery Store

FATHER
12. Name: William H. Crandall
13. Birthplace: Glenburnie

MOTHER
14. Maiden name: Margaret Driggs
15. Birthplace: Talbot Co Md

16. Informant: Ruth Grinages
Address: Lothian Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 4 1948 (month) (day) (year)
Cemetery or crematory: Quaker Home
Location: Galesville Md

18. Funeral director: F. C. Saudstrop Inc
Address: Galesville Md

19. 3/3 48 (Date rec'd by registrar) M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1948, at 9:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1948 to March 2 1948 and that I last saw him alive on March 2, 1948.

	DURATION
Immediate cause of death: Acute Pneumonia (Heart and respiratory failure)	3 days
Due to: C.A. Carcinoma Liver	7 years
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Shadyside Md. Date signed 3/3/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 02393

Reg. Diat. No. 28

1. PLACE OF DEATH:
County A. A.
City or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Crownsville, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route 1.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME William J. Engle (Engle)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	M.

6.(b) Name of husband or wife Fanny L. Engle
6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 2-26-1880

8. AGE: Years	Months	Days	If less than one day
68	—	—	hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual occupation Superintendent
11. Industry or business Crownsville St. Hosp.

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden name Walker
15. Birthplace —

16. Informant Fanny L. Engle
Address Crownsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 8/48 (month) (day) (year)
Cemetery or crematory Baldwin Memorial
Location Millersville Md
18. Funeral director B. I. Hopkins & Son
Address Annapolis Maryland

19. 3/6 1948 E. J. Joyce Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1948, at 11 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1947 to March 4 1948 and that I last saw him alive on March 4 1948

Immediate cause of death	DURATION
Coronary occlusion	sudden death
Due to Chronic hypertension	1 year
Other conditions —	—

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of Injury — Injured at work?

23. SIGNATURE Chas Marquette M.D.
M. D. or other
Address Crownsville Date signed 3-5-48

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

02394

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 303 N. Taylor Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: EMMA M. ENZINGER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph S. Enzinger

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Sept, 4, 1888

8. AGE: Years	Months	Days	If less than one day
59	6	8	...hrs. ...min.

9. Birthplace: Annapolis, A.A. Co., Maryland
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: William W. Morris

13. Birthplace: Annapolis, Maryland

MOTHER — 14. Maiden name: Sadie Myers

15. Birthplace: Annapolis, Maryland

16. Informant: Mr. Joseph S. Enzinger

Address: 303 No. Taylor Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-15-48 (month) (day) (year)

Cemetery or crematory: St. Anne's Cemetery

Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. March 15 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1948 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947, to March 12 1948 and that I last saw h[illegible] alive on 8 P.M. March 19...

Immediate cause of death	DURATION
Generalized Arteriosclerosis	
Cerebral Thrombosis	24 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed 3-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 02395

CERTIFICATE OF DEATH

Reg. Diat. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: a a

City or town: Galts

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Galts

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rurol, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph V. Ford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 1 — 1885

8. AGE:

Years	Months	Days	If less than one day
62	3	20	..... hrs. ..... min.

9. Birthplace: a a co. md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Geo G. Ford

13. Birthplace: md

MOTHER

14. Maiden name: Susian C Carr

15. Birthplace: Maryland

16. Informant: Amos. Carr

Address: Galts Stations md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 22/48 (month) (day) (year)

Cemetery or crematory: Baldwin Memorial

Location: Millersville. Md.

18. Funeral director: P. L. Hopkins & Son

Address: Annapolis Maryland

19. 3/20 48 E. F. Joyce Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 1948 at 4:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1948, to March 20 1948 and that I last saw h.i.m. alive on March 20 1948.

Immediate cause of death: Hypertensive & Arteriosclerotic Heart Disease — DURATION: 9 Years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edward J Hewitt M.D. M. D. or other

Address: Gambrills Md Date signed: Mar 20, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

180 02396

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Lawson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred: Telegraph Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Lawson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Telegraph Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Richard Lee Goodeke

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): January xx, 1946

8. AGE: Years: 2 Months: 2 Days: 4 If less than one day: hrs. min.

8. Birthplace: Severn, Md. R.F.D

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: James A Goodeke

13. Birthplace: Baltimore, Md

MOTHER

14. Maiden name: Ayta L. Weber

15. Birthplace: Baltimore

16. Informant: James A. Goodeke.

Address: Severn, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/29/48 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 3/26 (Date rec'd by registrar) 1948 L. J. Dellabetta Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 26 1948, at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that ~~I attended deceased~~ from ..... 19.. to ..... 19.. and ~~that I last saw him~~ alive on ..... 19..

Immediate cause of death	DURATION
Suffocation	
Due to: smoke	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Mar. 26, 1948

Where did injury occur? Lawson (City or town) Anne Arundel (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Burning home Injured at work?

23. SIGNATURE: E. Peyton Ritchie, M.D. (M.D. or other)

Address: Annapolis, Md. Date signed: Mar. 26, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02397

Reg. Diat. No. E-8

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 4 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 6 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Washington, D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 767 Columbia Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: HENRY HACKLEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 71 (1877)

8. AGE:	Years	Months	Days	If less than one day
	71	?	?	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Taylor Hackley
13. Birthplace: Virginia

MOTHER
14. Maiden name: Alice Lewis
15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3/17/48 (month) (day) (year)

Cemetery or crematory: Washington D.C.

Location:

18. Funeral director: L. E. Murray

Address: 1337-10 St. Ard.

19. 3/16 1948 by J. Joyce Lowe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15th 1948, at 5:44 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 11th 1947 to March 15th 1948 and that I last saw him alive on March 15th 1948

Immediate cause of death	DURATION
Generalized Arteriosclerosis	Known to us since 9/11/47
Due to:	
Due to:	
Other conditions: Psychosis With Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 9/11/47

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Marquette M. D.
M. D. or other

Address: Crownsville, Maryland Date signed: 3/16/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

16a

02398

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 hours

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Annapolis, Md.

How long in hospital or institution? Born here.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Annapolis,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 196 Green Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Boy Hanson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	infant

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			8 hrs. ..... min.

9. Birthplace: U.S. Naval Hospital Annapolis Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER
12. Name: Emil Herman Hanson
13. Birthplace: North Dakota,

MOTHER
14. Maiden name: Lena Langley
15. Birthplace: Wilson, N. C.

16. Informant: Hospital Records
Address: Annapolis - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 9/48 (month) (day) (year)

Cemetery or crematory: Naval Cemetery

Location: Annapolis - Md

18. Funeral director: B & H Hopkins & Son

Address: Annapolis Md

19. March 9 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-7-48 19 ..... at 11:31 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2:27 P.M. 3/7/48 19 ..... to 11:31PM 3/7 19 48

and that I last saw h. i.m. alive on 3/7/48 11:31 PM 19 .....

Immediate cause of death	DURATION
Anoxemia	
Due to: Congenital Atelectasis of both lungs.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Congenital Atelectasis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Grant R Mueller M. D. or other

Address: U.S. Naval Hospital Annapolis, Md. Date signed: 3-8-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 02399

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred:
U.S. Naval Hospital, Annapolis, Maryland
How long in hospital or institution? 3 months, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Pendenis Mount, Route 2
(If rural, give LOCATION)
2.(a) If veteran, name war World War 1 and World War 2

3. (a) FULL NAME
Samuel Milby HARRINGTON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Marion N. Harrington (wife) 6.(c) If alive, give age 57 yrs years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1882

8. AGE: Years	Months	Days	If less than one day
65	4	18	....hrs. ....min.

9. Birthplace Annapolis, Anne Arundel, Maryland (Town, county, and state)
10. Usual occupation None. Officer USMC-retired
11. Industry or business None

FATHER
12. Name P. F. Harrington
13. Birthplace Dover, Deleware

MOTHER
14. Maiden name M. N. Ruan
15. Birthplace St. Croix, Virgin Islands

16. Informant Mrs. Marion N. Harrington (wife)
Address Pendenis Mount Route 2 Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/2/48 (month) (day) (year)
Cemetery or crematory Naval Academy Cemetery
Location Annapolis, Md.
18. Funeral director John M. Taylor Son
Address Annapolis Md.
19. April 1, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 March 1948 19.... at 805 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 47 to 31 March 19 48 and that I last saw him alive on 30 March 19 48

Immediate cause of death	DURATION
PNEUMONIA, HYPOSTATIC #1829	
Due to CORONARY HEART DISEASE #237	
Due to ARTERIOSCLEROSIS	
Other conditions Assoc. Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operation No operations Date of op.
Autopsy results Not done.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. M. DAVIS, CDR (MC) U.S.Navy. M. D. or other
Address USNH, Annapolis, Md. Date signed 3-31-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

D. A. Anderson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

02400

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
at residence
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 31 Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward A. Hesselbrock

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Marie P. Hesselbrock
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 26th 1881

8. AGE:

Years	Months	Days	If less than one day
66	8	3	____ hrs. ____ min.

9. Birthplace: Newport, Kentucky (Town, county, and state)
10. Usual occupation: Secretary
11. Industry or business: Enterprise Bldg. & Loan

FATHER
12. Name: Henry Hesselbrock
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs. E. A. Hesselbrock
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/1/48 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cemetery
Location: Annapolis, Maryland

18. Funeral director: John M. Taylor, Inc.
Address: Annapolis, Md.

19. April 1, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29, 1948 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1948 to March 29, 1948 and that I last saw h. alive on March 29, 1948

Immediate cause of death: Coronary Thrombosis — DURATION: Minutes

Due to: (Antecedent causes)

Due to:

Other conditions: Arteriosclerosis — Cardiovascular disease — 4 yr.
(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. M. D. or Coroner
Address: Annapolis, Md. Date signed 4/1/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107 02401

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Annapolis Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Quarters S-4 North Severn
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JEFFREY EUGENE HINDMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Infant

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 3-14-48

8. AGE: Years	Months	Days	If less than one day
		3	hrs. min.

9. Birthplace: Annapolis, Anne Arundel Md.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Stanley Eugene Hindman
13. Birthplace: Glen Ferry, Idaho

MOTHER
14. Maiden name: Earnestine Virginia Pennington
15. Birthplace: True, W. Va.

16. Informant: LT. Comdr. STANLEY E. HINDMAN
Address: QUARTERS S-4, North Severn

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 3/18/48 (month) (day) (year)
Cemetery or crematory: Naval Academy Cemetery
Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son
Address: Annapolis, Md.

19. March 18 1948 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 March 1948 19 , at 3:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 14 March 19 48 to 17 Mar. 19 48
and that I last saw him alive on 17 March 19 48

	DURATION
Immediate cause of death: Broncho-pneumonia	48 hrs.
Due to: Congenital atelectasis of left lung	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R Moeller Cdr. (MC) USN
M. D. or other
Address: Annapolis, Md. Date signed 3-17-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

02402

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2days

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: BastGate
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural Nr. Annapolis RFD
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SARAH JANE HOMBERG

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James E. Homberg

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 4, 1889

8. AGE: Years	Months	Days	If less than one day
58	11	5	____ hrs. ____ min.

9. Birthplace: Anne Arundel Co., Maryland
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER
12. Name: Columbus Rogers
13. Birthplace: Maryland

MOTHER
14. Maiden name: Margaret Whittington
15. Birthplace: Maryland

16. Informant:

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-12-48 (month) (day) (year)

Cemetery or crematory: Edward's Chapel

Location: Parole, A.A. Co. Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. March 12 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9, 1948 at 12:50 a M

21. I CERTIFY that death occurred on the date above stated: ~~I last attended deceased from~~
Postmortum Examunation 19____
and that I last saw ~~him~~ alive on March 9, 1948

Immediate cause of death	DURATION
Sever Concussion of Brain	2days
Due to Hemorrhage in lower left abdomen	2days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 3-7-48

Where did injury occur? Deale (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?) Highway # 256

Means of injury: Auto turned over Injured at work? No

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other

Address: Annapolis Md Date signed 3-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

922 02403

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Sandtills. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1½ years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Sandtills. P.O
(If outside city or town limits, write RURAL and give nearest town)
Street No. Defense Highway
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME John Hunt, Jr.

3.(b) Social Security Number 213-12-2972

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Geraldine Hunt
6.(c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) June 13. 1919

8. AGE: Years	Months	Days	If less than one day
28	9	1	....hrs. ....min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Truck driver and laborer in Pet.
11. Industry or business Sand + Gravel Pit
FATHER 12. Name John Hunt Sr.
13. Birthplace Rhoads, Balto Co. Maryland
MOTHER 14. Maiden name Mamie Susie Morris
15. Birthplace Coeyesville Balto Co. Md
16. Informant William T. Hunt
Address 713 West 33rd St. Baltimore 11, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/17/48 (month) (day) (year)
Cemetery or crematory Park Chapel
Location Park Md.
18. Funeral director Paul E. Lehmann Jr.
Address 2615-17 Chestnut Ave.
19. 3/16 (Date rec'd by registrar) 19 48 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 19 48 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem Examination ~~and that I last saw h... alive on~~ March 14. 1948

	DURATION
Immediate cause of death	
Acute Dilatation of Heart	sudden
Due to Chronic Valvular Heart	
Disease.	Unknown
Due to Chronic Anemia (Splenic)	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did Injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of Injury ..... Injured at work?

23. SIGNATURE John M. Caffy M.D., Deputy Medical Examiner. (M. D. or other)
Address Annapolis, Md. Date signed 3-14-48

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02404

932

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: A A Co 11 W 24th Ave

City or town: Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: A A Co

City or town: Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 11 W. 24th Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Katherine Jasper

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife: John Jasper

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 6th 1863

8. AGE: Years: 84 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation:

11. Industry or business: At Home

FATHER — 12. Name: Henry Priensteadt

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Dont Know

MOTHER — 15. Birthplace: Germany

16. Informant: Miss Freda Jasper

Address: 11 W. 24th Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 24th (month) (day) (year)

Cemetery or crematory: Western Cemetery

Location: Catonsville

18. Funeral director: Wellwood Funeral Home

Address: 200 Arlington Ave

19. 3-22-48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20th 1948 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan-15 1948 to March 20 1948 and that I last saw h.. alive on March 19 1948

Immediate cause of death	DURATION
Coronary Thrombosis	8 hrs
Due to: Generalized Arterio-Sclerosis	
Due to: Cardio-Vascular Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Paul Lurion M.D.

M. D. or other

Address: 320 Patapsco Ave Date signed: 3/20/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02405

61

21

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Anne Arundel

City or town: Mt. Pleasant Beach Pasadena P.O. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For non-born infant, give residence of mother)

State: Maryland County: Anne Arundel

City or town: Mt. Pleasant Beach, Pasadena P.O.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Wharf Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Grace T. Jett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
femal	white	married

6.(b) Name of husband or wife: Thomas P. Jett

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Mar. 7. 1888

8. AGE: Years	Months	Days	If less than one day
60	0	3	...hrs. ...min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Home

FATHER
12. Name: F. Henry Rose
13. Birthplace: ~~Pennsylvania~~ Wheeling W. Va

MOTHER
14. Maiden name: Florence Seaman
15. Birthplace: Wheeling W. Va

16. Informant: Mrs. Florence M. Haynie
Address: Pasadena P.O. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/13/48 (month) (day) (year)

Cemetery or crematory: Woodlawn

Location: Woodlawn Md.

18. Funeral director: John F. Denny Inc.

Address: 76 Eight St.

19. March 12 48 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10, 1948 at 7:45 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination

~~and that I last saw h... alive on~~ ... 19...

Immediate cause of death	DURATION
Coronary Embolism	Sudden
Due to: Coronary Sclerosis	autumn
Due to: Diabetes Mellitus	8 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy, M.D. Deputy Medical Examiner
M. D. or other

Address: Annapolis, Md. Date signed: 3-10-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

81a

02406

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since March 6, 1948

Hospital, Institution, or street address where death occurred:
Emergency Hospt.

How long in hospital or institution? Entered Hospt. March 6, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: EAstPort Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 116 Eastern Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Alexander Ander Johnson

3.(b) Social Security Number: 217-18-0505

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Florence Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 21, 1913

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
34	9	20		

9. Birthplace: EastPort Md. A. A. Co.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER
12. Name: William Johnson
13. Birthplace: Anne Arundel Co.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Miss Adelle Johnson
Address: 116 Eastern Ave. Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 12- 48 (month) (day) (year)

Cemetery or crematory: Fowlers Chapel Cemetery

Location: Best Gate Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. March 11 19 48 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1948 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1948 to March 10 1948 and that I last saw him alive on March 10 1948

Immediate cause of death	DURATION
Meningitis - Etiology undetermined.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Emmitsburg Date signed 3-10-48.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159 02407

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ———

Hospital, Institution, or street address where death occurred:
60 Larkins St. Annapolis Md.

How long in hospital or Institution? ———

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 60 Larkins St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3.(a) FULL NAME

Baby Boy Johnson; NATHANIEL FRANK

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S.

6.(b) Name of husband or wife: ———

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): March 6, 1948

8. AGE: Years | Months | Days | If less than one day: 30 min.

9. Birthplace: Annapolis, Md.
(Town, county, and state)

10. Usual occupation: ———

11. Industry or business: ———

FATHER
12. Name: Nathaniel Frank Johnson
13. Birthplace: Oklahoma

MOTHER
14. Maiden name: Mable Hall.
15. Birthplace: Annapolis, Md.

16. Informant: Mable Hall
Address: 60 Larkin St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 8, 1948 (month) (day) (year)

Cemetery or crematory: Brewer Hill Cemetery

Location: West Street Extended

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St Annapolis Md.

19. March 8 19 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1948 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1948, to March 6 1948 and that I last saw him alive on March 6 1948

Immediate cause of death	DURATION
Miscarriage (5 1/2 mo. foetus)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work?

23. SIGNATURE: M. F. Klawans MD
M. D. or other

Address: Annapolis, Md. Date signed: 3/6/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

Dr. Richardson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

02408

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH
County A. A.
City or town Waterbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Waterbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James H. Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Anna Jones
6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) June 1 1871

8. AGE: Years 76 Months 9 Days If less than one day ....hrs. ....min.

9. Birthplace Davidsonville
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name William Jones
13. Birthplace A. A.

MOTHER
14. Maiden name Hagler (Unknown)
15. Birthplace Md.

16. Informant James Jones
Address Waterbury

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Mar. 17/48
(month) (day) (year)
Cemetery or crematory John Wesley
Location Waterbury

18. Funeral director J. B. Johnson
Address Annapolis

19. March 17 19 48 C. F. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 13 19 48 at 7:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 28 19 48 to March 13, 19 48
and that I last saw him alive on March 13, 19 48

Immediate cause of death	DURATION
Pneumonia Hypostatic	1 Day
Due to Bronchi - Pneumonia	16 Days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. L. Richardson M. D.
M. D. or other
Address Annapolis, Md. Date signed 3/16/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

Dr. Claffy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97 02409

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Davidsonville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: above
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: SARAH ROSELLA KING

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Benjamin R. KIng
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 27, 1871

8. AGE:

Years	Months	Days	If less than one day
76	4	26	hrs. min.

9. Birthplace: Davidsonville, A.A. Co. Maryland
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sarah Grimes
15. Birthplace: Maryland

16. Informant: Mr. Edward C. King
Address: Edgewater Post Office, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-25-48 (month) (day) (year)
Cemetery or crematory: All Hallows Chapel
Location: Davidsonville, Maryland

18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland

19. March 25 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 1948 at 2.50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 1948 to Mar. 23 1948 and that I last saw h... ev... alive on March 23 1948

Immediate cause of death	DURATION
Acute Cardiac failure	sudden
Due to Auricular fibrillation	3 years
Due to Arterio-Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy M.D
M. D. or other
Address: Annapolis Md. Date signed: 3-24-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02410

167

CERTIFICATE OF DEATH

Reg. Diat. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County A. A.

City or town Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 2 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A.

City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 824 Boucher Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME CARRIE MARY LAWTON

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOW

6.(b) Name of husband or wife George W. Lawton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 27, 1883

8. AGE: Years	Months	Days	If less than one day
64	10	20	....hrs. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Peter Bernhardt
13. Birthplace Maryland

MOTHER
14. Maiden name ?
15. Birthplace ?

16. Informant Mrs. Mary Scanlon - daughter
Address 824 Boucher Ave. Eastport. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/22/48 (month) (day) (year)

Cemetery or crematory OAK LAWN CEMETERY
Location Baltimore, Md.

16. Funeral director HENRY SANDER & SONS, INC.
Address NORTH AVE. & BROADWAY

19. 3-19 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18. 1948, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 1948, to March 18 1948
and that I last saw h[illegible] alive on March 18 1948

Immediate cause of death	DURATION
Bronchopneumonia	48 hrs.
Hypostatic congestion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Lunt Leach M. D. or other

Address Eastport, Maryland Date signed 3-16-48.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

02411

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 29 Annapolis Road, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: EDNA MAY LUEDTKE

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Martin W. Luedtke

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): October 15, 1895

8. AGE: Years	Months	Days	If less than one day
52	5	8	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER

12. Name: George G. Wheeler

13. Birthplace: Baltimore, Md.

MOTHER

14. Maiden name: Mary Kelty

15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Agness Novak

Address: Green Haven, Pasadena, Md. P.O.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 26, 48 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 3/25 19.... (Date rec'd by registrar) L. J. Oda Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 19 48 at 2.15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/19/46 19.. to 3/23/48 19..

and that I last saw h.. alive on 3/23/48. 19..

Immediate cause of death: Mitral Insufficiency — DURATION: 2 yrs.

Due to: Interstitial nephritis — 2 yrs.

Due to: Enlarged heart.

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - NO Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Gustave K. Faucher M.D. M. D. or other

Address: Glen Burnie, Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

02412

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Marley Park (Glen BurniеP.O.)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:
The Greenway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A.A.Co.

City or town: Marley Park (Glen BurniеP.O
(If outside city or town limits, write RURAL and give nearest town)

Street No.: The Greenway
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SCHUYLER MARKS

3.(b) Social Security Number: 215-02-2652

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Lillie A. Marks

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): January 8, 1890

8. AGE: Years	Months	Days	If less than one day
58	2	2	..... hrs. ..... min.

9. Birthplace: Brooklyn, Md.
(Town, county, and state)

10. Usual occupation: Watch & Fire Dept. Forman

11. Industry or business: U.S. Industrial Chem. Inc.

FATHER
12. Name: William F. Marks
13. Birthplace: Freeport, Pa.

MOTHER
14. Maiden name: Sarah Jane Cunningham
15. Birthplace: Kitannig, Penn.

16. Informant: Mrs. Lillie A. Marks
Address: The Greenway, Marley Park Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 2, 1948 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Maryland

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. 4/2 19 48 L.J.Oakes
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 19 48 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/29/48 19 to 3/30/48 19 and that I last saw him alive on 3/30/48 19

Immediate cause of death	DURATION
Coronary Infart	Sudden.
Due to: Rupture of the heart -	
Due to: Bronchial asthma	3 days.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gustave H. Faubert M.D.
M. D. or other

Address: Glen Burnie Md. Date signed: 3/31/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Lyphart

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 129

02413

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. Carvel Hall - Prince Geo. St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John M. Maubert

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Rose White Maubert

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 1st 1875

8. AGE:

Years	Months	Days	If less than one day
73	4	13	hrs. min.

9. Birthplace Berlin Germany (Town, county, and state)

10. Usual occupation Insurance man, ret.

11. Industry or business

FATHER 12. Name John M. Maubert

13. Birthplace Germany

MOTHER 14. Maiden name unknown

15. Birthplace unknown

16. Informant Mrs. W. W. Waller Arlington Va.

Address 1615 N. Wakefield St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/17/48 (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Md.

18. Funeral director John M. Taylor - Son

Address Annapolis, Md.

19. March 17 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 19 48, at 6:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-27 19 48 to 3-14 19 48 and that I last saw h 14 alive on 3-14-48 19

Immediate cause of death	DURATION
Pertonitis generalized	
Broncho Pneumonia	
Due to Arteriosclerosis generalized	
Severe Renal Bilateral	
Due to Adenocarcinoma Bladder	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E J Trumbull M. D. or other

Address Annapolis Md. Date signed 3-15-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

548

02414

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: LAUREL (RURAL)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 year
Hospital, institution, or street address where death occurred:
DISTRICT TRAINING SCHOOL
How long in hospital or institution? 18 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: Anne Arundel
City or town: LAUREL, Md - rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mildred MICHINARD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): MAY 24 - 1922

8. AGE: Years 25 | Months 8 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: RALPH.
13. Birthplace: New Orleans, LA.

MOTHER
14. Maiden name: Mildred FRANCIS
15. Birthplace: New York

16. Informant: History - of - D.T.S.
Address: Hosp. Record

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 10-48 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Wash. D.C.

18. Funeral director: W.W. Chamblin Co
Address: Riverdale, Md.

March 7 1948 James Seay
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 7 1948 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946 to MAR 7 1948 and that I last saw h.er alive on MAR. 7 1948

Immediate cause of death	DURATION
Tumor of BRAIN; malignant (Enterprise)	4 years
Due to	
Due to	
Other conditions: Mental Deficiency - Moron	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. D. Huff MD
M. D. or other
Address: Laurel, Md Date signed 3-7-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

180 02415

CERTIFICATE OF DEATH

BC Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jones Station - P.O. Arnold
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since October - 1947
Hospital, institution, or street address where death occurred:
Iwago - Vista Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 200 - east Lafayette
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME MARTIN EDGAR MUELLER
Martin Edgar Mueller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married.

6.(b) Name of husband ~~or wife~~: Louise Lenabel Mueller
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Nov. 4 - 1887

8. AGE:

Years	Months	Days	If less than one day
60	4	8	....hrs. ....min.

9. Birthplace: Oklahoma.
(Town, county, and state)
10. Usual occupation: Retired seaman
11. Industry or business: Chief Quarter Master U.S.N.

FATHER
12. Name: Martin J. Mueller
13. Birthplace: Kentucky -

MOTHER
14. Maiden name: Louise Cherry
15. Birthplace: Virginia

16. Informant: Mrs. M.E. Mueller (wife)
Address: Jones Station - P.O. Arnold.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/15/48 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore Maryland
18. Funeral director: John M. Taylor Son
Address: Annapolis Maryland

19. March 15 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 19 48 at 2.20 A.M.
I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
suffocation due	
to smoke	sudden
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 3/12/48
Where did injury occur? Jones station A.A. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home.
Means of injury: Fire. Injured at work? No

23. SIGNATURE: Gustave H. Faubert M.D.
acting deputy Coroner
Address: Glen Burnie, Md. Date signed 3/17/48

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MAPGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

97 02416

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County Anne Arundel
City or town Brooklyn Park (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, institution, or street address where death occurred: Cedar Hill
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infanta give residence of mother)
State ... County ...
City or town ... (If outside city or town limits, write RURAL and give nearest town)
Street No. ... (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mr. John Bevern Mugford
3. (b) Social Security Number

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced Widowed.
6.(b) Name of husband or wife —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) October 17 - 1861

8. AGE: Years	Months	Days	If less than one day
86	4	13	... hrs. ... min.

9. Birthplace Wales - England (Town, county, and state)
10. Usual occupation Was a foreman in a
11. Industry or business Copper Smelter
FATHER 12. Name John Mugford
13. Birthplace England
MOTHER 14. Maiden name Elizabeth ?
15. Birthplace England
16. Informant Mr. Thomas J. Mugford
Address Brooklyn Park, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 4-48 (month) (day) (year)
Cemetery or crematory Mt Carmel Cemetery
Location O'Donnell St Balto. Md
18. Funeral director Milton Schilling
Address 3914 Hanover St.
19. March 3 1948 (Date rec'd by registrar) Ida M. Whitman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st 1948, at 2:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to date 19..
and that I last saw him alive on 2/20/48 19..

Immediate cause of death	DURATION
acute nephritis	2 years
Due to cerebral arteriosclerosis	?
Due to cystitis -	?
Other conditions Prostatitis -	?

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Gustave H. Parker M.D. M. D. or other
Address 5 Ferndale ... Glen Burnie, Md. Date signed 3/1/48

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61 B 02417

Reg. Diat. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 hrs.
Hospital, institution, or street address where death occured:
Station Hospital.
How long in hospital or institution? 68 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County: — —
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1270 New Hampshire Ave N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: — —

3.(a) FULL NAME: Murphy, PATRICK HENRY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5 August 1856

8. AGE: Years	Months	Days	If less than one day
91	7	18	— hrs. — min.

9. Birthplace: Dublin Ireland
(Town, county, and state)
10. Usual occupation: Minister
11. Industry or business

FATHER
12. Name: Patrick Henry Murphy
13. Birthplace: Belfast, Ireland

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Col Geo W. Rice., MC
Address: Fort George G. Meade, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Mar 27 48 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Crematory
Location: Prince George County, Md.

18. Funeral director: S. H. Hines & Co
Address: Washington D.C.

19. 23 Mar 48 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 1948 at 2.05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1948 to March 23 1948 and that I last saw him alive on March 23 1948

Immediate cause of death	DURATION
Arteriosclerotic Heart Disease & Congestive Heart Failure	
Due to:	
Due to:	
Other conditions: Osteitis mult. ves, Chr. glomerulo nephritis & Uremia.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Melville C. Magida 1st Lt. M.C.
M. D. or other
Address: Sta. Hosp. Ft. Geo Meade Date signed: Mar 23 1948

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d 02418

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: West River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: West River
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cumberstone
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Henry Murray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Susan Harrison Murray
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 8th 1868

8. AGE: Years 79 | Months 7 | Days 13 | If less than one day: hrs. min.

9. Birthplace: Washington Va
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Dr Jas. H. Murray
13. Birthplace: West Riva A.A.C Md

MOTHER
14. Maiden name: Frankina Cheston
15. Birthplace: Baltimore Md.

16. Informant: E Churchill Murray
Address: Cumberstone A.A.C Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-24-48 (month) (day) (year)
Cemetery or crematory: Christ Church Yard
Location: Owensville Md
18. Funeral director: John M. Taylor Son
Address: Annapolis Md

19. March 24 1948 (Date rec'd by registrar) M M Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 22 1948 at 6 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1942 to Mar. 22 1948 and that I last saw h[illegible] alive on Mar 22 1948

Immediate cause of death	DURATION
Gen. Arteriosclerosis	
Arteriosclerotic cardio vascular disease	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S. Bowsock M.D.
M. D. or other
Address: Annapolis Md Date signed: 3/23/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 02419

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County a. a.

City or town Linthicum
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County a. a.

City or town Linthicum
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1320 Broadview Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war Yes World War #1

3. (a) FULL NAME Wm Major Powell

3. (b) Social Security Number 705-10-8602

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Evelyn Powell

6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Jan 8 - 1897

8. AGE: Years	Months	Days	If less than one day
51	2	2	....hrs. ....min.

9. Birthplace Ridge Md.
(Town, county, and state)

10. Usual occupation Clerk for R.R.

11. Industry or business Western Maryland R.R.

FATHER
12. Name Henry Powell
13. Birthplace Virginia

MOTHER
14. Maiden name Elizabeth Custis
15. Birthplace Virginia

16. Informant Evelyn V. Powell

Address 1320 Broadview Blvd. Linthicum Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 3/13/48 (month) (day) (year)

Cemetery ~~or crematory~~ Oaancock Va

Location

18. Funeral director Wm. Cook Inc.

Address 1217 St. Paul St.

19. March 11 1948 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 10 1948, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9- 1939 to Mar. 10 1948 and that I last saw h.. alive on Mar. 10 1948

Immediate cause of death	DURATION
Cardio - Vascular	9 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bare Jr. M.D. M. D. or other

Address Linthicum Date signed 3-10-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 02420

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Gr. Geo

City or town: Upper Marlboro (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS PROCTOR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1857

8. AGE: Years	Months	Days	If less than one day
91	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: John Proctor

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary?

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-13-48 (month) (day) (year)

Cemetery or crematory: Mt Carmel

Location: Upper Marlboro Md

18. Funeral director: Ritchie Bros

Address: Upper Marlboro Md

19. 3/11/48 (Date rec'd by registrar) E T Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10th 1948, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 13th 1948, to March 10th 1948 and that I last saw him alive on March 10th 1948

Immediate cause of death	DURATION
Generalized Arteriosclerosis	Known to us since 2/13/48
Due to:	
Due to: Senile Psychosis	Known to us since 2/13/48
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Muenster M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 3/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for addition of birth date and change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 02421

File No. G 115 APR 12 1948

Reg. Diat. No. 58

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 26 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 1 month, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 546 McMechen
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: QUICK - AGNES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 13, 1885

8. AGE: Years	Months	Days	If less than one day
62? 62	7 10	7 13	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Green Leathers

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Georgina Tears Sears

MOTHER — 15. Birthplace:

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/29/48 (month) (day) (year)

Cemetery or crematory: Baltimore Md

Location:

18. Funeral director: Charles A. Law

Address: 802 Madison Ave.

19. 3/26 48 (Date rec'd by registrar) E. Joyce Love Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 19 48 at 12:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 30 19 48 to March 26 19 48 and that I last saw her alive on March 26 19 4

Immediate cause of death	DURATION
General and Cerebral Arteriosclerosis	Known to us sunce Jan. 30, 1948
Due to:	
Due to:	
Other conditions: Psychosis With Cerebral Arteriosclerosis	Known to us since 1/30/48

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Mengerster M. D.
M. D. or other

Address: Crownsville, Maryland Date signed: 3/26/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

02422

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Davon, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Davon, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Infant Boy Rawlings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	—

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 14, 1948

8. AGE: Years | Months | Days | If less than one day: 15 min. hrs.

9. Birthplace: Davon, Md (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name: Robert Andrew Rawlings

FATHER 13. Birthplace: Upper Marlboro, Md

MOTHER 14. Maiden name: Lillian Virginia Kidwell

MOTHER 15. Birthplace: Mt. Calvert, Pr. Ges. Co

16. Informant: Robert Rawlings Address: [redacted], Davon, Md

17. Burial, cremation, or removal. Which? Burial Date thereof 3/15/48 (month), (day), (year)

Cemetery or crematory: Home of A. Rawlings

Location: Davon, Md

18. Funeral director: Robert A. Rawlings

Address: Davon, Md

19. 3/15 1948 (Date rec'd by registrar) W. H. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Mar 1948, at 3:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Mar 1948, to 14 Mar 1948

and that I last saw h.y.n. alive on 14 Mar 1948

Immediate cause of death	DURATION
Atelectasis	15 min.
Due to: Prematurity	—
Due to: Premature Labor - 26 wks	—
Other conditions	—

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. B. Janes M. D. or other

Address: Upper Marlboro, Md. Date signed: 14 Mar 48

M

I

T

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1154

02423

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Harwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? died in auto on way to

Hospital, institution, or street address where death occurred: Johns Hopkins HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Davidsonville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Betty Ann Rawlings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 28, 1947

8. AGE: Years | Months: 11 | Days: 29 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Upper Marlboro, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Raymond K. Rawlings

13. Birthplace: Davidsonville, Md.

MOTHER — 14. Maiden name: Helen Simms

15. Birthplace: Harwood, Md.

16. Informant: Raymond R. Rawlings

Address: Davidsonville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/29/48 (month) (day) (year)

Cemetery or crematory: Chews

Location: West River, Md.

18. Funeral director: T.A. Hardesty & Son

Address: Galesville, Md.

19. 3/29 19 48 (Date rec'd by registrar) M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 19 48 11.30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 19 48, to March 27 19 48 and that I last saw h. alive on March 27 19 48

Immediate cause of death	DURATION
~~Coma~~ pneumonia	
Due to: fish bone in bronchia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frieda H. Wilson M. D. or other

Address: Lothian, Md. Date signed 3/29/48

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

124 L 02424

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 265 Hanover St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Caroline White Reese

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: George Newton Reese
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 31st 1885

8. AGE:

Years	Months	Days	If less than one day
62	9	12	hrs. min.

9. Birthplace: Portsmouth, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Joan White
13. Birthplace: Virginia

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs. Ralph J. Michels, San Pedro
Address: 2805 Bay Water Av. Calif.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/16/48 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: John M. Taylor Son
Address: Annapolis, Md.

19. March 16 1948 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1948 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1948 to 1948
and that I last saw her alive at that time. 1948

Immediate cause of death	DURATION
Cirrhosis of liver.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Not done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jesse W. Miller
Jesse W. Miller, Capt. (MC) USN
Address: Annapolis, Md. Date signed:

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02425

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years, 7 months, 3 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 29 years, 7 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME

ROBIN SON - FLORENCE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Thomas Clark

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years	Months	Days	If less than one day
59	?	?	....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: John Davis
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ellen Hinson
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/31/48 (month) (day) (year)

Cemetery or crematory: Quaker Neck Cemetary

Location: Kent County, Md.

18. Funeral director: J. Willis Wells
Address: Chestertown, Md.

19. 3/29, 1948 (Date rec'd by registrar) E T Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25th 19 48, at 5:00P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 41 to March 25 19 48 and that I last saw her alive on March 25 19 48

Immediate cause of death	Pulmonary Tuberculosis	DURATION: Known to us since 1947
Due to		
Due to		
Other conditions	Schizophrenia	Known to us since Oct. 22, 1918

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of .....

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----------

Means of injury ..... Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other

Address: Crownsville, Maryland Date signed 3/25/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02426

93d

Reg. Diat. No. 23

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Glen Burnie. 204 2nd Av SW.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 204 - 2nd Ave., S. W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Sara Margaret Mackey Ross -

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married -

6.(b) Name of husband or wife: Frank B. Ross.

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Sept 17, 1885.

8. AGE: Years	Months	Days	If less than one day
62	5	24	....hrs. ....min.

9. Birthplace: Bentley Springs, Maryland.

(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business: At home.

FATHER

12. Name: Samuel Charles Augustus Mackey -

13. Birthplace: Maryland.

MOTHER

14. Maiden name: Sarah Isabella Bentley

15. Birthplace: Maryland.

16. Informant: Victoria Ross.

Address: Glen Burnie. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/13/48 (month) (day) (year)

Cemetery or crematory: Lorraine Cem.

Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 3-12-48 (Date rec'd by registrar) 19.... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March March 11 19.48, at 6 45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19.46, to March 11 19.48

and that I last saw her alive on March 9 19.48

Immediate cause of death	DURATION
Coronary Thrombosis	30 minutes
Due to: Cardio Vascular Disease	3 years.
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: None.

Date of op. 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James S. Billingsley M.D.

M. D. or other

Address: Glen Burnie Md Date signed March 11, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

02427

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 152 Prince Geo. St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clifton J. Russell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Mary A. Russell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 17th 1872

8. AGE: Years: 75 | Months: 10 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Annapolis, A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: electrician (ret.) U.S.N.A

11. Industry or business

FATHER — 12. Name: Josiah Russell

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Hutchinson

15. Birthplace: Maryland

16. Informant: Mary A. Russell

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/13/48 (month) (day) (year)

Cemetery or crematory: St. Anns Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor-Son

Address: Annapolis Md

19. March 13 19 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 19 48 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 19 48 to March 10 19 48 and that I last saw h.im alive on March 10 19 48

Immediate cause of death	DURATION
Cerebral Apoplexy	4 days
Due to: Arterial Hypertension	several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Olivier Purcell M. D. or other

Address: Annapolis Md Date signed: 3/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02428

FILM No. G 115 APR 14 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Arnold
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, institution, or street address where death occurred:
Old Annapolis Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Arnold
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Old Annapolis Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: LOLA G. SCHMIDT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Otto H. Schmidt

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): June 30, 1884

8. AGE: Years	Months	Days	If less than one day
63 64	8	25	...hrs. ...min.

9. Birthplace: Maryland Anne Arundel
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: William H. Sappington

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Annie Boone

MOTHER — 15. Birthplace: Maryland

16. Informant: Mr. Otto H. Schmidt

Address: Arnold Post Office, Arnold, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-27-48 (month) (day) (year)

Cemetery or crematory: Asbury Methodist Cemetery

Location: Arnold Anne Arundel Co. Maryland

19. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. (Date rec'd by registrar) March 27 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 25 1948, at 4 45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4 1946 to Mar 25 1948 and that I last saw her alive on Mar. 24 1948

Immediate cause of death	DURATION
arteriosclerotic cardiovascular disease	6 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: S. Bosworth MD
M. D. or other

Address: Annapolis Md Date signed: 3/29/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

02429

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1305 West St.

(If rurel, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Minnie E. Schutz

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: John Schutz

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 6th 1881

8. AGE: Years: 66 Months: 7 Days: 14 If less than one day: hrs. min.

9. Birthplace: New York (Town, county and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER — 12. Name: Anthony Stumpf

13. Birthplace: Germany

MOTHER — 14. Maiden name: Anna Rehmke

15. Birthplace: New York

16. Informant: John Schutz

Address: 1305 West St. Annapolis Md.

17. (Burial, cremation, or removal. Which?) Cremation Date thereof: May 22 1948 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Prince Geo Co. Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. March 22 19 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 20th 1948 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1942 19 to Mar 20 1948

and that I last saw her alive on Mar 20 1948

Immediate cause of death	DURATION
Carcinoma Lung	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: Edmonston Md. Date signed: 3/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

02430

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A A

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Conduit

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Tom Selk

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Mongol	Married

6.(b) Name of husband or wife: Tong Silk

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown 1883

8. AGE: Years: About 65 Months: — Days: — If less than one day: hrs. min.

9. Birthplace: China (Town, county, and state)

10. Usual occupation: Laundry

11. Industry or business

FATHER — 12. Name: Unknown; 13. Birthplace:

MOTHER — 14. Maiden name: Unknown; 15. Birthplace:

16. Informant: Hom Hing

Address: 1845 Broadway N. Y. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/10/48 (month) (day) (year)

Cemetery or crematory: Lorraine Park Cemetery

Location: Baltimore, Maryland

18. Funeral director: John M. Taylor & Son

Address: Annapolis Md.

19. Mar. 9 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 1948 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1948 to March 7 1948 and that I last saw him alive on March 7 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	36 hrs
Due to: Hypertension	adm
Due to:	
Other conditions: Arteriosclerosis	36 hrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Boyd M. D. or other

Address: Annapolis Md. Date signed: 3-9-48

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

164c 02431

CERTIFICATE OF DEATH

Reg. Diat. No. 28 21

1. PLACE OF DEATH
County: Anne Arundel
City or town: Oak Rd. Whitneys Landing, Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For stillborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severna Park
(If outside city or town limits, write RURAL, and give nearest town)
Street No. Oak Rd. Whitneys Landing
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Dorothea Smith

3.(b) Social Security Number

4. Sex: female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Leonard Bayard Smith II
6.(c) If alive, give age: 31 years
7. Birth date of deceased (mo., day, yr.): Jany. 19. 1916

8. AGE: Years: 33 Months: 1 Days: 18 If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Hank Lollmann
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden name: Beulah
15. Birthplace: North Carolina

16. Informant: Leonard Bayard Smith II
Address: Severna Park, R.D., Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 10 1948 (month) (day) (year)
Cemetery or crematory: Indue Rd.
Location: Hyderia Rd
18. Funeral director: L. Heeman & Son
Address: 6067 Hanford Rd

19. 3-10 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1948 about 10 A M

21. I CERTIFY that death occurred on the date above stated: the cause(s) stated was/were diagnosed from Post-mortem Examination and/or was/were verified by autopsy. March 8 1948

	DURATION
Immediate cause of death: Bullet Wound in Chest	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 3-8-48
Where did injury occur: Whitneys Landing (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: 32 cal. bullet Injured at work? no

23. SIGNATURE: John M. Cleffy, M.D., Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed: 3-8-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166 02432 21

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Oak Road, Whitney's Landing (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year Severna Park
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severna Park (If outside city or town limits, write RURAL and give nearest town)
Street No.: Oak Road, Whitney's Landing (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Leonard Bayard Smith III

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	—

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 11, 1944

8. AGE: Years	Months	Days	If less than one day
3	7	26	hrs. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation: —
11. Industry or business: —

FATHER
12. Name: Leonard Bayard Smith II
13. Birthplace: Baltmor, Md.

MOTHER
14. Maiden name: Dorathea Lellman
15. Birthplace: Baltimor, Md

16. Informant: Leonard Bayard Smith II
Address: Severna Park, P.O., Md.

17. Burial (Burial, cremation, or removal (Which?)) Date thereof: March 11 48 (month) (day) (year)
Cemetery or crematory: Fordum Rd.
Location: Frederick Rd
18. Funeral director: L. HECMANN & SON
Address: 6067 Harford Rd.
19. 3-10 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1948 at about 10A M
21. I CERTIFY that death occurred on the date above stated: Post Mortem Examination March 8 1948

Immediate cause of death	DURATION
Due to: Bullet wound in Chest	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of: 3-8-48
Where did injury occur? Whitney's Landing (City or town) Anne Arundel (County) Md. (State)
Injured at home, farm, industry, public place (where?): Woods
Means of injury: 32 cal. bullet Injured at work? no

23. SIGNATURE: John M. Claffy, M.D. Deputy Medical Examiner (M. D. or other)
Address: Annapolis, Md. Date signed: 3-8-48

Crafton

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124 R

02433

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 41 Randall St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Archie Wm Southern

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Thelma Southern

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 30th 1893

8. AGE: Years	Months	Days	If less than one day
54	7	20	..... hrs. ..... min.

9. Birthplace: Vicksburg, Kentucky (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: —

FATHER — 12. Name: William Southern

13. Birthplace: Kentucky

MOTHER — 14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Thelma Southern

Address: 41 Randall St.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3-20-48 (month) (day) (year)

Cemetery or crematory: Monocacy, Pa.

Location:

18. Funeral director: John M. Taylor Co. Inc.

Address: Annapolis, Md.

19. March 20 19 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1948 at 11 20 P. M

21. I CERTIFY that death occurred on the date above stated: [illegible] Post Mortem Examination

and that the cause was: March 19 1948

	DURATION
Immediate cause of death:	
Anemia	unknown
Due to: Hemorrhage from Hemorrhoids	unknown
Due to: Cirrhosis of Liver	unknown
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy medical examiner

Address: Annapolis, Md. M. D. or other

Date signed: 3-20-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

938 02434

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH
County A A Co
City or town GREENLAND BEACH
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County A A Co
City or town GREENLAND BEACH
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARGARET Squires

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEM	WHITE	WIDOW

6.(b) Name of husband or wife BEO A SQUIRES
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 4 1872

8. AGE: Years 76 | Months | Days 18 | If less than one day hrs. min.

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual occupation HOUSE WORK

11. Industry or business AT HOME

FATHER 12. Name CHAS HOPPE
13. Birthplace GERMANY

MOTHER 14. Maiden name NOT KNOWN
15. Birthplace NOT KNOWN

16. Informant ALFRED A. Squires
Address 6 N Fontaine AVE

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 3-29-48 (month) (day) (year)
Cemetery or crematory CEDAR HILL
Location A A Co

18. Funeral director Bernard E Harke
Address 121 E West St

19. March 27 1948 (Date rec'd by registrar) Ida M Whitson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1948, at 5-58 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1948 to March 25 1948 and that I last saw h.m. alive on March 25 1948.

	DURATION
Immediate cause of death Degenerative Cardio Vascular Disease	4 yrs
Due to Hypertension	4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Brady Smith M.D.
M. D. or other
Address Riviera Beach, Md. Date signed 3/25/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02435

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A.A.
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A.A.
City or town Brooklyn, Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 44 Thomas Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Hiram Frederick Sullivan

3. (b) Social Security Number

4. Sex M.
5. Color or race W
6.(a) Single, married, widowed, or divorced W.
6.(b) Name of husband or wife Lilly Rehlang
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 12/12/1866

8. AGE: Years 81 Months 3 Days 5 If less than one day ... hrs. ... min.

9. Birthplace Illinois
(Town, county, and state)
10. Usual occupation —
11. Industry or business
FATHER 12. Name George
13. Birthplace Ireland
MOTHER 14. Maiden name Anna Denny
15. Birthplace Illinois
16. Informant Family
Address Same.
17. B. Date thereof 3-20-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Western
Location Edmondson. Ave.
18. Funeral director James J. McCully
Address 130 E. Fort Ave.
19. 3-19 1948 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 17 1948 at 5 A. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 15 1947 to Mar 17 1948
and that I last saw him alive on Mar 17 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis	indef.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. E. [illegible] M. D. or other
Address [illegible] Date signed 3/18/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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02436

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery County
City or town: Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. ---
(If rural, give LOCATION)
2.(a) If veteran, name war --

3. (a) FULL NAME: ROY THORNTON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ---
7. Birth date of deceased (mo., day, yr.): Approximately 48 1900

8. AGE:

Years	Months	Days	If less than one day
48?			...hrs. ...min.

9. Birthplace: --
(Town, county, and state)
10. Usual occupation: --
11. Industry or business: --

FATHER
12. Name: Unknown
13. Birthplace: --

MOTHER
14. Maiden name: Unknown
15. Birthplace: --

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 3/26/48
(month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: State Hospital
Address: Crownsville Md

19. 3/26 1948 E. T. Joyce Coroner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 19 48 at 8:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 19 48 to March 23 19 48 and that I last saw him alive on March 23 19 48

Immediate cause of death: Encephalomalacia of Basal ganglia — DURATION: Known to us since March 19 1948

Due to: Arteriosclerosis

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ---

Autopsy results: Encephalomalacia of Basal Ganglia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. --- Date of ---
Where did injury occur? ---
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury: Injured at work?

23. SIGNATURE: Jacob Amorgentum M.D.
M. D. or other
Address: Date signed:

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117a 02437 2

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rock View Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Bal Co.

City or town: Rock View Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Benjamin Tully

3. (b) Social Security Number: 218-03-4394

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Adele Hyland

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5/13/1897

8. AGE:

Years	Months	Days	If less than one day
50	9	22	hrs. min.

9. Birthplace: Near Balto Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Edgewood Arsenal

FATHER — 12. Name: John Tully

FATHER — 13. Birthplace: Ohio

MOTHER — 14. Maiden name: Nellie Shea

MOTHER — 15. Birthplace: Md.

16. Informant: Mrs C. B Tully. Address: Rock View Beach

17. Burial, cremation, or removal. Which?: Burial. Date thereof: 3/8/48 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Federal Hill

18. Funeral director: J. J Zoller & Sons. Address: 1308 Light St.

19. 3-6-1948 (Date rec'd by registrar) Accepted Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 4 1948 at 4 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 4 1948 to Mar 4 1948 and that I last saw h— alive on — 19—

Immediate cause of death	Coronary Thrombosis	Sudden
Due to	Ulcer of Stomach	
Due to	Obesity	
Other conditions		

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos. H Dudley M. D. or other

Address: 3307 Edmondson Date signed: 3-5-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02438

CERTIFICATE OF DEATH

Reg. Diat. No. 21

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1110 Mitchell Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Walter A. Whittington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Irene E Whittington

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10th 1881

8. AGE:	Years	Months	Days	If less than one day
	66	11	10	hrs. min.

9. Birthplace: A. A. Co. Maryland (Town, county, and state)

10. Usual occupation: Machinist Retired

11. Industry or business: U. S. Engineering Exper. Station

FATHER 12. Name: Alexander Whittington

13. Birthplace: A. A. Co. Md.

MOTHER 14. Maiden name: Mariah Hall

15. Birthplace: A. A. Co. Md.

16. Informant: Irene E. Whittington

Address: 1110 Mitchell St. Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/23/48 (month) (day) (year)

Cemetery or crematory: Edwards Chapel Cemetery

Location: Parole Maryland

18. Funeral director: John M. Taylor & Son

Address: Annapolis Maryland

19. March 23 19 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-21-48 19 at ✓ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19 47 to March 21 19 48

and that I last saw him alive on March 21 19 48

Immediate cause of death	DURATION
Cerebral Hemorrhage	8 Months & 1 Mo
Rt. Hemiplegia	
Due to: Hypertension	Intern
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Boyd M. D. or other

Address: Campbell Md. Date signed 3-22-48